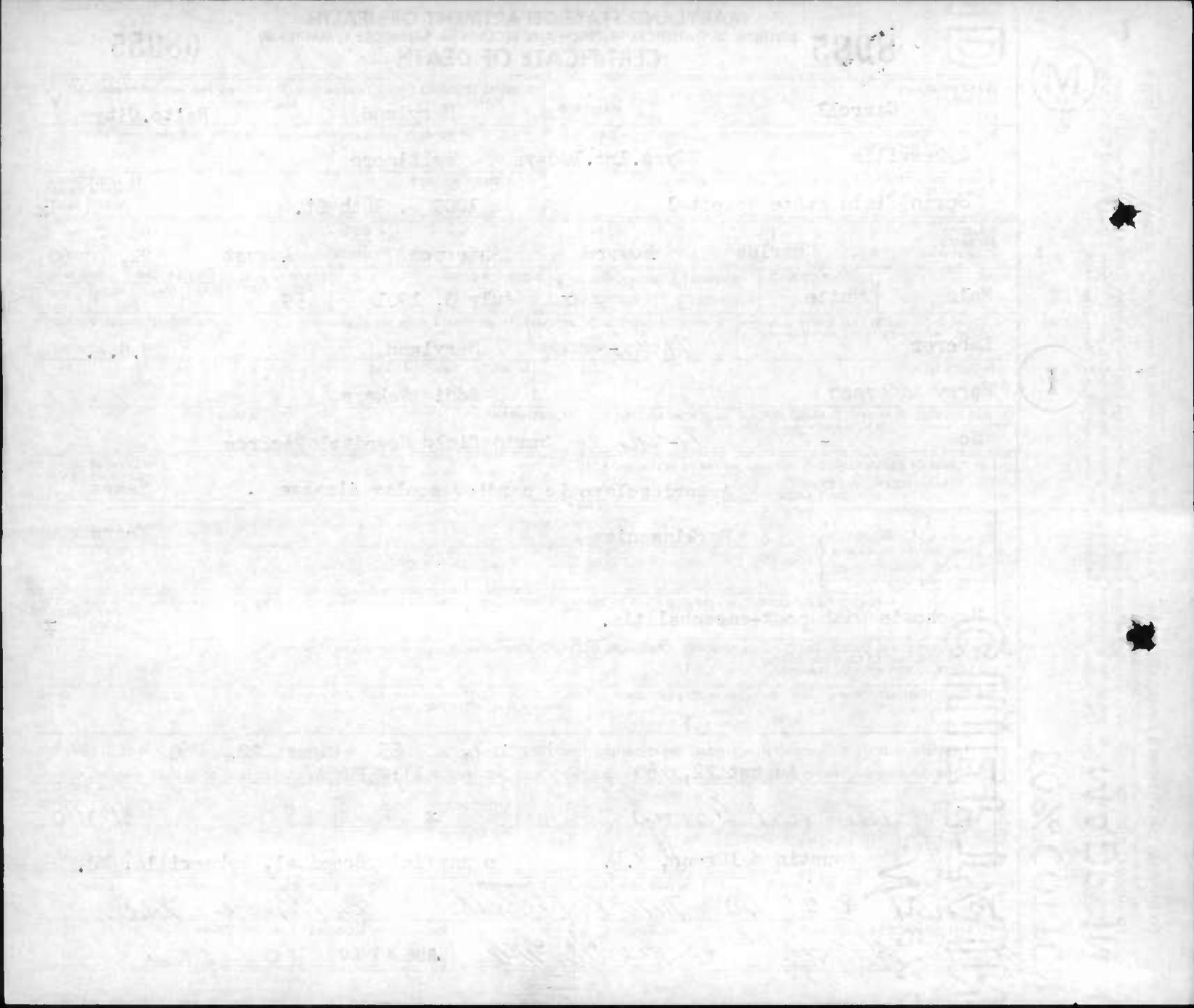


TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND												08955			
CERTIFICATE OF DEATH															
1. PLACE OF DEATH a. COUNTY Carroll MARYLAND						2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. City ✓									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville			c. LENGTH OF STAY IN 1b 22yrs. 1mo. 10days			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			d. STREET ADDRESS 1009 W. 38th St.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Charles Middle Edward Last Anderson								4. DATE OF DEATH August 22, 1960		Month	Day	Year			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH July 3, 1901		9. AGE (In years last birthday) 59 yrs.		IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY Unknown				11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Harry Anderson						14. MOTHER'S MAIDEN NAME Addie Sakers									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. 709			17. INFORMANT Springfield Hospital Records			Address						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]												INTERVAL BETWEEN ONSET AND DEATH Years			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 350X (b) Parkinsonism												Years			
DUE TO (c)															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Psychosis with post-encephalitis.												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Springfield Hospital			20f. (City or town) Baltimore			(County)	(State)		
21. I certify that (I) (this hospital) attended the deceased from March 7, 1955, to August 22, 1960, that (I) (we) last saw the deceased alive on August 22, 1960, and that death occurred at 11:45 PM the causes and on the date stated above.															
22a. SIGNATURE Agustin del Campo						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22b. DATE SIGNED 8/23/60			
22c. PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.						22d. ADDRESS Springfield Hospital, Sykesville, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 8-27-60			23c. NAME OF CEMETERY OR CREMATORIUM New Cathedral			23d. LOCATION (City, town, or county) Baltimore, Md.						
24. FUNERAL DIRECTOR'S SIGNATURE Arthur J. Haight						ADDRESS Sykesville, Md.						25a. REC'D BY REGISTRAR DAUG 31 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



TO HOSPITAL OR ATTENDING PHYSICIAN: law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8986

08956

1. PLACE OF DEATH o. COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 2 Mos. 23 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
3. NAME OF DECEASED (Type or print) Katherine Butler		First Katherine	Middle Butler
4. DATE OF DEATH August 24, 1960		Month August	Day 24
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
		WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 10-12-87		9. AGE (In years lost birthday) 72 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -----	11. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME James Butler		14. MOTHER'S MAIDEN NAME Anastasia Concoran	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -----	17. INFORMANT Springfield Hospital Records, Sykesville, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		Address	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X		Cerebral hemorrhage due to hypertension.	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO		INTERVAL BETWEEN ONSET AND DEATH Hemorrhage 10 days.	
(c)		Hypertension years.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) C.B. S. assoc. with cerebral arteriosclerosis with psychotic reaction.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from June 1, 1960 to August 24, 1960 , that (I) (we) last saw the deceased alive on August 24, 1960 , and that death occurred at 12:30 P.M. from the causes and on the date stated above.		22. SIGNATURE Agustin del Campo	
22c. PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.		M.D. <input type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22d. ADDRESS Springfield State Hospital, Sykesville, Md.	22b. DATE SIGNED August 24, 1960
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Aug 27, 1960	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS New Cathedral Cemetery
24. FUNERAL DIRECTOR'S SIGNATURE John A. Moran		23d. LOCATION (City, town, or county) Baltimore, Maryland	25a. REC'D BY REGISTRAR AUG 29 '60
		25b. REGISTRAR'S SIGNATURE Charles S. Kraus	

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HEAD FOR LIBRARY

8228



TO HOSPITAL OR ATTENDING PHYSICIAN: low requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

Item 16 Film 6271 9-16-60 et

08957

1. PLACE OF DEATH a. COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Taneytown		c. LENGTH OF STAY IN 1b 15 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION West Baltimore St. (Ext.)		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Taneytown	
3. NAME OF DECEASED (Type or print) John		First Donald	Middle Boone
4. DATE OF DEATH August	Last Boone	Month Month	Day 9
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 20, 1906
9. AGE (In years last birthday) 53 yrs.	10. IF UNDER 1 YEAR Months 53	11. IF UNDER 24 HRS. Days 53	12. Hours 53
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Route Salesman	10b. KIND OF BUSINESS OR INDUSTRY Bakery	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME John W. Boone		14. MOTHER'S MAIDEN NAME Carrie Wolfe	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 218-14-8338	17. INFORMANT Mrs. J. Donald Boone
		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intracranial Hemorrhage	Address Taneytown, Md.
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. 331X		DUE TO (b) Hypertension and Arteriosclerosis	INTERVAL BETWEEN ONSET AND DEATH Few Min.
		DUE TO (c)	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m.	Month Day Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) Taneytown	(County) Carroll	(State) Md.	
21. I certify that (I) (this hospital) attended the deceased from 12/10/59 to 8/9 , 19 60 , that (I) (we) last saw the deceased alive on 8/1 19 60 and that death occurred at P.M. from the causes and on the date stated above.			
22a. SIGNATURE R. S. McVaugh	M.D. <input type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 8/10/60	
22c. PHYSICIAN'S NAME (Type) R. S. McVaugh	22d. ADDRESS Taneytown, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Aug. 12, 1960	23c. NAME OF CEMETERY OR CREMATORIAL St. Mary's Cemetery	23d. LOCATION (City, town, or county) Silver Run, Carroll, Maryland
24. FUNERAL DIRECTOR'S SIGNATURE Merwyn C. Fuss	ADDRESS Taneytown, Md.	25a. REC'D BY REGISTRAR AUG 15 '60	25b. REGISTRAR'S SIGNATURE Arthur S. Krause

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AMERICAN LIBRARIES
IN THE SOVIET UNION

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FOR STATE
HEALTH DEPT.



To DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any day is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

8987

08958

1. PLACE OF DEATH

a. COUNTY

Carroll

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Westminster

c. LENGTH OF STAY IN 1b

10 HOURS

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

RURAH

First

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Middle

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)

a. STATE

Maryland

b. COUNTY

Carroll

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Union Bridge

d. STREET ADDRESS

18 So. MAIN ST

Last

Month

Day

Year

e. IS RESIDENCE
ON A FARM?

YES NO

3. NAME OF
DECEASED
(Type or print)

GEORGE

K.

BOSTIAN

August 30,

1960

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED

NEVER MARRIED

WIDOWED

DIVORCED

8. DATE OF BIRTH

4/21/1922

9. AGE (In years
last birthday)

38 yrs.

10. IF UNDER 1 YEAR

Months Days

Hours Min.

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

LABORER CONSTRUCTION

MARYLAND

12. CITIZEN OF WHAT COUNTRY?

U.S.

13. FATHER'S NAME

WILLIAM H. BOSTIAN MARY GRIM

Address

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (Check one word before service)

YES

16. SOCIAL SECURITY NO.

WART 217-18-8742V

17. INFORMANT

H. BOSTIAN, UNION BRIDGE MD

INTERVAL BETWEEN
ONSET AND DEATH

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic coronary disease with old infarct

bx of left anterior ventricle

Conditions, if any, which
give rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY
PERFORMED?

YES NO

20e. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING
CAUSE OF DEATH

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m.
p.m.

20d. INJURY OCCURRED
While at work Not While at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion
death resulted from: Natural causes Accident Suicide Homicide Undetermined manner

ACTUAL
SIGNATURE

Russell S Fisher

CHIEF MEDICAL EXAMINER

M.D. ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

Address (Street, city, town, or county)

DATE SIGNED

8/31/60

22a. BURIAL, CREMATION,
REMOVAL (Specify)

23. FUNERAL DIRECTOR

22b. DATE THEREOF

19/2/60

ADDRESS

22c. NAME OF CEMETERY OR CREMATORIUM

WINTERS OPEN CEMETERY

22d. LOCATION (City, town, or country)

(State)

24a. REC'D BY REGISTRAR

SEP 6 '60

24b. REGISTRAR'S SIGNATURE

Arthur S. Kraus

REACH TO FORM UNITED STATES OF AMERICA
THE 1950'S IN A HOSPITAL. SENT HOME IN HIS BROTHER'S BAG. HE WOULD NOT TALK.
20120. REACH TO ESTABLISHED ESTIMATE OF CHARGE 1802

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REACH TO ESTABLISHED ESTIMATE OF CHARGE
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TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "prior" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 5 may be retained for your information.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8989 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 18960

1. PLACE OF DEATH a. COUNTY CARROLL CO. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE MARYLAND COUNTY CARROLL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAMPSTEAD		c. LENGTH OF STAY IN 1b 7 MOS.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) —		e. STREET ADDRESS DAVE RILL RD. 1	
f. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) EMMANUEL BOSTICK CUNNINGHAM		First	Middle
4. DATE OF DEATH Month Aug Day 20 Year 1960		Last	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> MAY 1, 1888	9. AGE (In years, last birthday) 72 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TELEGRAPHER		10b. KIND OF BUSINESS OR INDUSTRY RAIL ROAD	11. BIRTHPLACE (State or foreign country) PENNSYLVANIA
13. FATHER'S NAME ALBERT CUNNINGHAM		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 705-05-7957	17. INFORMANT MRS. CUNNINGHAM
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		Address HAMPSTEAD MD	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis		INTERVAL BETWEEN ONSET AND DEATH 1 hr	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b)			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .		DATE SIGNED Aug 21-1960	
ACTUAL SIGNATURE W.H. Foard		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) W. H. Foard M.D.		22b. DATE THEREOF 8/23/60	
22c. NAME OF CEMETERY OR CREMATORIAL MEADOWRIDGE CEM.		22d. LOCATION (City, town, or county) LAWRAL MD.	
23. FUNERAL DIRECTOR'S SIGNATURE James G. Saffell Washington		24a. REC'D BY REGISTRAR DATE AUG 23 '60	
ADDRESS REG.		24b. REGISTRAR'S SIGNATURE John S. Evans	

STATE OF HAWAII
DEPARTMENT OF DEFENSE
HAWAII STATE GUARD

CHIEF OF STAFF
HAWAII STATE GUARD
CPT. ROBERT L. KELLY

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8990

08961

1. PLACE OF DEATH a. COUNTY Carroll		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Baltimore City		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 1 yr. 19 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 12		d. STREET ADDRESS 723 Benninghaus Road		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Margaret		First	Middle	Last	4. DATE OF DEATH du Bois	Month	Day	Year
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH February 17, 1905	9. AGE (In years last birthday) 55 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Michael Finn				14. MOTHER'S MAIDEN NAME Ella Brannen				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or date of service) NO		16. SOCIAL SECURITY NO. 214-01-7732		17. INFORMANT		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia						INTERVAL BETWEEN ONSET AND DEATH 24 hours		
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Infected decubitus ulcers						Weeks		
(b) DUE TO Metastatic carcinoma in the liver and thoracic spine secondary to carcinoma of the breast.						Unknown		
(c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Depressive Reaction						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from July 14 , 19 59 to August 3 , 19 60 , that (I) (we) last saw the deceased alive on August 3 , 19 60 , and that death occurred at 8:05 P.M. from the causes and on the date stated above.								
22a. SIGNATURE Agustin del Campo		M.D.		ATTENDING PHYS. <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input checked="" type="checkbox"/>	22b. DATE SIGNED August 3, 1960	
22c. PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.				22d. ADDRESS Springfield Hospital, Sykesville, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/8/60		23c. NAME OF CEMETERY OR CREMATORIAL Moreland Memorial Pk. Cemetery		23d. LOCATION (City, town, or county) Baltimore, Maryland		(State)
24. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Lechner & Sons		ADDRESS Bethel - 12 Nrd		25a. REC'D BY REGISTRAR DATE AUG 8 '60		25b. REGISTRAR'S SIGNATURE James E. Thomas		

100-3040 STATION 3

4422

STATION 3

500' DEPTH

1000' DEPTH

1500' DEPTH

2000' DEPTH

2500' DEPTH

3000' DEPTH

3500' DEPTH

4000' DEPTH

4500' DEPTH

5000' DEPTH

5500' DEPTH

6000' DEPTH

6500' DEPTH

7000' DEPTH

7500' DEPTH

8000' DEPTH

8500' DEPTH

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9500' DEPTH

10000' DEPTH

10500' DEPTH

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41000' DEPTH

41500' DEPTH

42000' DEPTH

42500' DEPTH

43000' DEPTH

43500' DEPTH

44000' DEPTH

44500' DEPTH

45000' DEPTH

45500' DEPTH

46000' DEPTH

46500' DEPTH

47000' DEPTH

47500' DEPTH

48000' DEPTH

48500' DEPTH

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49500' DEPTH

50000' DEPTH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08962

Reg. Dist. No.

CERTIFICATE OF DEATH

8991

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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PLACE OF DEATH a. COUNTY Carroll		MARYLAND		2. USUAL RESIDENCE [Where deceased lived. If institution: Residence before admission] a. STATE Maryland		b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Sykesville		c. LENGTH OF STAY IN 1b 2yr.1mo.12days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Woodbine		d. STREET ADDRESS Route # 1	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Fannie	Middle Louise	Last ESCAVAILLE	4. DATE OF DEATH	Month August	Day 23	Year 1960
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 2-5-86	9. AGE (In years last birthday) 74 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Harry Sullivan		14. MOTHER'S MAIDEN NAME Louisa Gibson					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 4nd -		INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC Heart Disease INTERVAL BETWEEN ONSET AND DEATH years							
420.1 DUE TO CORONARY Arteriosclerosis years							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Nephrosclerosis, chronic years							
(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic brain syndrome associated with circulatory disturbance, with cerebral arteriosclerosis, with psychotic reaction.							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7-11 , 19 58 , to 8-23 , 19 60 , that I last saw the deceased alive on August 23 , 19 60 , and that death occurred at 12Noon , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)							
ACTUAL SIGNATURE Ilse Kammler, M. D. DATE SIGNED 8-23-60							
PHYSICIAN'S NAME (Type)		Sykesville, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF August 26, 1960		22c. NAME OF CEMETERY OR CREMATORIUM Druid Ridge		22d. LOCATION (City, town, or county) Pikesville, Baltimore, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Arthur A. Height of Sykesville, Md.		ADDRESS		24a. REC'D BY REGISTRAR AUG 29 '60		24b. REGISTRAR'S SIGNATURE Orilia S. Thomas	

REF ID: A6462

- 1068

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 & 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8992

08963

1. PLACE OF DEATH o. COUNTY Carroll		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Baltimore ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 4mos. 3days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 19		d. STREET ADDRESS 1318 Forrest Road	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Alfred	Middle	Last Evans	4. DATE OF DEATH	Month August	Day 4,	Year 1960
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH September 9, 1872	9. AGE (In years last birthday) 87 yrs.	IF UNDER 1 YEAR Months 87	IF UNDER 24 HRS. Hours 03 X - 2	Year 00
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) Kentucky		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Hyron Evans				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. —		17. INFORMANT Springfield Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO Bronchopneumonia (c)							
INTERVAL BETWEEN ONSET AND DEATH Years 422.1 Days							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) C.B.S. assoc. with senile brain disease with psychotic reaction.							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from March 31, 1960 , to August 4, 1960 , that (I) (we) last saw the deceased alive on August 4, 1960 , and that death occurred 10:05 AM from the causes and on the date stated above.							
22a. SIGNATURE Agustini del Campo		M.D.		ATTENDING PHYS. <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input checked="" type="checkbox"/>	22b. DATE SIGNED 8/4/60
22c. PHYSICIAN'S NAME (Type) Agustini del Campo, M.D.		22d. ADDRESS Springfield Hospital, Sykesville, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 8-6-60		23b. DATE THEREOF 8-6-60		23c. NAME OF CEMETERY OR CREMATORIAL Meadowridge		23d. LOCATION (City, town, or county) (State) Baltimore Md.	
24. FUNERAL DIRECTOR'S SIGNATURE John O'Connelly		ADDRESS Essex 21 md.		25a. REC'D BY REGISTRAR DATE AUG 8 '60		25b. REGISTRAR'S SIGNATURE Clifford S. Thomas	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08964

8993

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Carroll</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural Westminster</i>		c. LENGTH OF STAY IN 1b 10 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Lester's Church Road</i>		e. STREET ADDRESS <i>Lester's Church Road</i>	
3. NAME OF DECEASED (Type or print) <i>JOHN THOMAS FORNEY</i>		First <i>JOHN</i>	Middle <i>THOMAS</i>
		Last <i>FORNEY</i>	4. DATE OF DEATH <i>Aug. 30 1960</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 5, 1880</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) <i>Keyesville, Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>George M. Forney</i>		14. MOTHER'S MAIDEN NAME <i>Isabelle Ohler</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) —		16. SOCIAL SECURITY NO. <i>—</i>	
INFORMANT <i>Mrs. John T. Forney, same address</i>		Address <i>—</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Recurrent Cerebral Thrombosis</i> DUE TO <i>332X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			
INTERVAL BETWEEN ONSET AND DEATH <i>5 mo.</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) —		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) —	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While Nat while at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) —	
21. I certify that I attended the deceased from <i>Jan. 1960</i> to <i>Aug 30 1960</i> , that I last saw the deceased alive on <i>Aug. 30, 1960</i> and that death occurred at <i>724½ M.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>M.C. Porterfield</i> PHYSICIAN'S NAME (Type) <i>M.C. Porterfield</i>			
22a. BURIAL, CREMATION, REMOVAL <i>Burial</i>		22b. DATE THEREOF <i>Sept. 2, 60</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>Greenwood Memorial Garden, Tanbark, Md.</i>		22d. LOCATION (City, town, or county) (State) <i>—</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. E. Myers, Jr., Westminster, Md.</i>		ADDRESS —	
		24a. REC'D BY REGISTRAR DATE <i>SEP 1 '60</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Trahan</i>

RECORDED IN ACCORDANCE WITH THE STATE OF TEXAS
LAW TO STABILIZE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8982

CERTIFICATE OF DEATH

Reg. Dist. No. 08965

1. PLACE OF DEATH a. COUNTY <i>Carroll</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Westminster</i>	c. LENGTH OF STAY IN 1b <i>75 yrs.</i>	b. COUNTY <i>Carroll</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>148 W. Main St.</i>	e. STREET ADDRESS <i>148 W. Main St.</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Westminster.</i>			
d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <i>CHARLES RYLE</i>	First <i>Charles</i>	Middle <i>FOUTZ</i>	Last <i>FOUTZ</i>		
4. DATE OF DEATH <i>August 2 1960</i>	Month <i>Aug.</i>	Day <i>2</i>	Year <i>1960</i>		
S. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Jan. 20 1873</i>		
9. AGE (In years, less birthday) yrs. <i>87</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. IF UNDER 24 HRS. Hours <i>0</i>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Medical Doctor, general practice</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Unincorporated</i>	11. BIRTHPLACE (State or foreign country) <i>Carroll, Md.</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>Joseph Foutz</i>	14. MOTHER'S MAIDEN NAME <i>Mary Roselot</i>	Address <i>148 W. Main St., Westminster, Md.</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>—</i>	17. INFORMANT <i>Charles R. Foutz Jr., Westminster, Md.</i>	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Thrombosis</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <i>Chronic Myocarditis</i> (b) DUE TO <i>Arteriosclerosis & calcification</i> (c)	INTERVAL BETWEEN ONSET AND DEATH <i>6 m</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>Westminster</i>	(County) <i>Carroll</i>	(State) <i>Md.</i>
21. I certify that I attended the deceased from <i>August 2 1960</i> to <i>Aug 2 1960</i> , that I last saw the deceased alive on <i>Aug 2 1960</i> , and that death occurred at <i>11:55 AM</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>Westminster, Md.</i> DATE SIGNED <i>8/3/60</i>					
ACTUAL SIGNATURE <i>Daleene Speicher</i>	PHYSICIAN'S NAME (Type) <i>Daleene Speicher</i>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Carroll Aug. 5, 1960</i>	22b. DATE THEREOF <i>Aug. 5, 1960</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Kendall Cemetery</i>	22d. LOCATION (City, town, or county) <i>Rural Westminster, Md.</i>	(State) <i>Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. E. Melo, Jr., Westminster, Md.</i>	ADDRESS <i>—</i>	24a. REC'D BY REGISTRAR DATE <i>AUG 8 '60</i>	24b. REGISTRAR'S SIGNATURE <i>C. L. S. Kraus</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-trust permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

100

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08966

Reg. Dist. No.

CERTIFICATE OF DEATH

8994

1. PLACE OF DEATH a. COUNTY <i>Carroll</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural Jembury Rd #35 yrs</i>		c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Inner Road</i>	
d. STREET ADDRESS <i>Inner Road</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <i>WILLIAM</i>	Middle <i>GERALD</i>	Last <i>FRIZZELL</i>
4. DATE OF DEATH	Month <i>AUG</i>	Day <i>17</i>	Year <i>1960</i>
S. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>Dec 12, 1924</i>
9. AGE (In years last birthday) <i>35 yrs.</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. IF UNDER 24 HRS. Hours <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>farmer & employee of Bluh & Decker</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Gas & Carroll Land. U.S.A.</i>	11. BIRTHPLACE (State or foreign country) <i>Rural Jembury Rd #1</i>	12. CITIZEN OF WHAT COUNTRY? <i>RTI</i>
13. FATHER'S NAME <i>WILLIAM B. FRIZZELL</i>	14. MOTHER'S MAIDEN NAME <i>ELLA GERTRUDE GREEN</i>	Address <i>Mrs. W. Gerald Frizzell Jembury Md</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>—</i>	16. SOCIAL SECURITY NO. <i>215-26-1945</i>	17. INFORMANT <i>Mrs. W. Gerald Frizzell Jembury Md</i>	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CORONARY THROMBOSIS</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)
			INTERVAL BETWEEN ONSET AND DEATH <i>20 MINUTES</i>
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour a. m. p. m. 19	20d. INJURY OCCURRED White Nat while at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>19 Ridge Road</i>	20f. (City or town) (County) (State) <i>WESTMINSTER MARYLAND</i>
21. I certify that I attended the deceased from <i>December, 1960</i> , to <i>August, 1960</i> , that I last saw the deceased alive on <i>August 17, 1960</i> , and that death occurred at <i>11:07 AM</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>19 Ridge Road</i> DATE SIGNED <i>8-17-60</i>			
ACTUAL SIGNATURE <i>Daniel I. Welliver M.D.</i>	PHYSICIAN'S NAME (Type) <i>DANIEL I. WELLIVER</i>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>8/20/60</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Deer Park Cemetery, Rural Westminster, Md.</i>	22d. LOCATION (City, town, or county) (State) <i>WESTMINSTER MARYLAND</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. S. Myers Jr., Westminster, Md.</i>	ADDRESS <i>Westminster, Md.</i>	24a. REC'D BY REGISTRAR <i>Arthur S. Krause</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Krause</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

(8967)

FOR STATE
HEALTH DEPT.

M

8995

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

V.S. A15ME
SM 2/57

1. PLACE OF DEATH a. COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 1yr. 6mos. 9days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		1534.2	
3. NAME OF DECEASED (Type or print) Mary Eloise Tonner		First Mary	Middle Eloise
4. DATE OF DEATH August 8, 1960		Last Garvey	Month Day Year
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH July 26, 1918
9. AGE (In years last birthday) 42	10. KIND OF BUSINESS OR INDUSTRY -	11. BIRTHPLACE (State or foreign country) Missouri	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Michael Tonnar		14. MOTHER'S MAIDEN NAME Clara Phister	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -	
17. INFORMANT Springfield Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) Interstitial pneumonia DUE TO 525 X Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Schizophrenic reaction, catatonic type.			
INTERVAL BETWEEN ONSET AND DEATH Day			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>James T. Marsh</i>		DATE SIGNED 8/8/60	
EXAMINER'S NAME (Type) James T. Marsh, M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 11, 1960	
22c. NAME OF CEMETERY OR CREMATORIAL Arlington Natl. Cem.		22d. LOCATION (City, town, or county) Arlington Va	
23. FUNERAL DIRECTOR'S SIGNATURE H. W. Devol		ADDRESS Wash. DC	
24a. REC'D BY REGISTRAR Arthur S. Kraus		24b. REGISTRAR'S SIGNATURE	
DATE AUG 15 '60			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

8998

CERTIFICATE OF DEATH

Items 1, 2 Film 6270 9-6-60 et

08968

1. PLACE OF DEATH a. COUNTY Carroll		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.		b. COUNTY Carroll		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville - rural		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Sykesville - rural				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Oakland Mill Rd.				d. STREET ADDRESS Oakland Mill Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) EDWARD		First R.	Middle GISBURNE	Last	4. DATE OF DEATH August 28 1960	Month	Day	Year
S. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 14, 1888	9. AGE (In years, last birthday) 71 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Owner		10b. KIND OF BUSINESS OR INDUSTRY Trucking Co.		11. BIRTHPLACE (State or foreign country) N. Y.		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME John Gisburne			14. MOTHER'S MAIDEN NAME unknown					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT Mr. Edward H. Gisburne-380 S. Kenilworth Ave.		Address Emhurst, Ill.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) EMBOLISM OF CORONARY ARTERY								
INTERVAL BETWEEN ONSET AND DEATH 20 min.								
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO ARTERIOSCLEROTIC HEART DISEASE								
15-20 yrs.								
(c) HYPERTENSIVE CARDIOVASCULAR DISEASE								
40 plus yrs.								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
19								
21. I certify that (I) (this hospital) attended the deceased from 1.9.60 to 8.28.60 , that (I) (we) last saw the deceased alive on 8.7.60 , and that death occurred at 10:30A am the causes and on the date stated above.								
22o. SIGNATURE Wm. H. Lawson, Jr., M.D.		M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 8.28.60	
22c. PHYSICIAN'S NAME (Type) Wm. H. Lawson, Jr., M.D.		22d. ADDRESS Liberty Rd. nr Eldersburg, Sykesville, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 8/31/60		23c. NAME OF CEMETERY OR CREMATORIAL Green Mount Crem.		23d. LOCATION (City, town, or county) (State) Baltimore, Md.		
24. FUNERAL DIRECTOR'S SIGNATURE John J. Lickner & Sons - Back 17		ADDRESS		25a. REC'D BY REGISTRAR Aug 30 '60		25b. REGISTRAR'S SIGNATURE C. E. S. Hause		

BOOK

AUDIO BOOK

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be retained by the hospital or attending physician.
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

68969

8997

Items 7, 15 Filing 270 9-6-60 et

1. PLACE OF DEATH o. COUNTY Carroll		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Baltimore City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 27 yrs. 6 mos. 10 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) d. STREET ADDRESS 1321 Cambria St.		d. STREET ADDRESS Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Henry		First	Middle	Last	4. DATE OF DEATH Graf	Month August	Day 30, 19 60
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 11, 1868	9. AGE (In years last birthday) 91 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Year 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pill maker		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry L. Graf				14. MOTHER'S MAIDEN NAME Charlotte			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No Yes Span-Amer.		16. SOCIAL SECURITY NO. -		17. INFORMANT Springfield Hospital Records		Address	
18. CAUSE OF DEATH [Enter any one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) Arteriosclerotic heart disease DUE TO Conditions, if any, which gave rise to immediate cause (o), stating the under- lying cause last. (b) Acute pancreatic duct abscess DUE TO (c)							
INTERVAL BETWEEN ONSET AND DEATH Years 420							
Weeks Acute pancreatic duct abscess							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) C.B.S. assoc. with circ. dist. with cerebral arteriosclerosis with psychotic reaction.							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from March 7, 1955 , to August 30, 1960 , that (I) (we) last saw the deceased alive on August 29, 1960 , and that death occurred at 6:10 AM from the causes and on the date stated above.							
22a. SIGNATURE Agustin del Campo		M.D.		ATTENDING PHYS. <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input checked="" type="checkbox"/>	22b. DATE SIGNED 8/30/60
22c. PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.		22d. ADDRESS Springfield State Hospital, Sykesville, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) 9-2-60		23b. DATE THEREOF 9-2-60		23c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill Cemetery		23d. LOCATION (City, town, or county) (State) Brooklyn 3d	
24. FUNERAL DIRECTOR'S SIGNATURE McCullly Funeral Home 130 E. Fort Ave		ADDRESS McCullly Funeral Home 130 E. Fort Ave		25a. REC'D BY REGISTRAR DATE SEP 1 '60		25b. REGISTRAR'S SIGNATURE Charles S. Krause	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

8998

CERTIFICATE OF DEATH

08970

1. PLACE OF DEATH a. COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 4 mos. 3 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Harriet	Middle Beulah	Last Grier
4. DATE OF DEATH August 4, 1960	Month August	Day 4	Year 1960
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED	8. DATE OF BIRTH April 6, 1887
9. AGE (In years last birthday) 73 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME WILLIAM T. GRIER	14. MOTHER'S MAIDEN NAME Harriet Harkins	Address	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO.	17. INFORMANT Springfield Hospital Records, Sykesville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 153.0 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO Metastatic carcinoma to the liver Months		INTERVAL BETWEEN ONSET AND DEATH 24 hours.	
(c) DUE TO Carcinoma of the cecum Months			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) CBS assoc. with senile brain disease, with psychotic reaction.			
20c. TIME OF INJURY Hour o. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from March 31, 1960 , to August 4, 1960 , that (I) (we) last saw the deceased alive on August 4, 1960 , and that death occurred at 4:10 A.M. the causes and on the date stated above.			
22a. SIGNATURE <i>Agustin del Campo</i>		M.D.	22b. DATE SIGNED August 4, 1960
22c. PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8-6-60	23c. NAME OF CEMETERY OR CREMATORIAL Glenwood Cemetery
23d. LOCATION (City, town, or county) Washington DC		(State)	
24. FUNERAL DIRECTOR'S SIGNATURE Deal Funeral Home		ADDRESS 4812 Ga Ave. NW DC	25d. REC'D BY REGISTRAR DATE AUG 9 '60
			25e. REGISTRAR'S SIGNATURE Arthur S. Thane

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health, Division of Mortuary Commission, or with the funeral director.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

8995

08971

CERTIFICATE OF DEATH

1. PLACE OF DEATH

a. COUNTY

Carroll

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Rural Keymar

c. LENGTH OF STAY IN lb

Lifetime

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)

a. STATE

Maryland

b. COUNTY

Carroll

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

Sharret Road

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

RuralKeymar

d. STREET ADDRESS

Sharret Road

e. IS RESIDENCE
ON A FARM?YES NO 3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

4. DATE
OF
DEATH

Month

Day

Year

Laura

Virginia

Hahn

August

11

1960

5. SEX

6. COLOR OR RACE

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

9. AGE (In years
last birthday)

83 yrs.

IF UNDER 1 YEAR

IF UNDER 24 HRS.

Male

White

WIDOWED DIVORCED

July 4, 1877

Months

Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY

Own Home

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Samuel Angell

14. MOTHER'S MAIDEN NAME

Mary Brown

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)

No

(If yes, give war or dates of service)

212-40-5984

16. SOCIAL SECURITY NO.

17. INFORMANT

Miss Thelma Hahn , Keymar, Md.. R.D.

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

422

DUE TO

Chronic Myocarditis
General debilityINTERVAL BETWEEN
ONSET AND DEATH

7 days

Conditions, if any, which
gave rise to immediate
cause (a), stating the under-
lying cause last.

(b)

DUE TO

(c)

2 yrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?
YES NO 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour o. m.
p. m. 1920d. INJURY OCCURRED
While
at work Not while
at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from _____ to _____ that (I) (we) last
saw the deceased alive on Aug. 10, 1960, and that death occurred at 2 AM, from the causes and on the date stated above.

22a. SIGNATURE

J. N. Legg

M.D.

ATTENDING
PHYS.MED.
DIRECTORSTAFF
PHYS.22b. DATE
SIGNED

Aug. 12, 1960

22c. PHYSICIAN'S
NAME (Type)

T. H. Legg MD

22d. ADDRESS

Elmwood Bridge Md

23a. BURIAL, CREMATION, REMOVAL (Specify)
BurialDATE THEREOF
Aug. 13, 1960

23c. NAME OF CEMETERY OR CREMATORIUM

Keysville Cemetery

23d. LOCATION (City, town, or county)

(State)

Keysville, Carroll, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE

C. E. Fuss & Son, Taneytown, Maryland

ADDRESS

25e. REC'D BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

DATE AUG 15 '60

Charles S. Krause

HTAIS TO THE STATE CHARTER

CHARTERS & BYLAWS PREPARED IN ACCORDANCE WITH THE REQUIREMENTS OF THE STATE OF TEXAS

HTAIS TO STATE, 1960

220 pages, 1960

1960

1960

1960

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100	101	102	103	104	105	106	107	108	109	110	111	112	113	114	115	116	117	118	119	120	121	122	123	124	125	126	127	128	129	130	131	132	133	134	135	136	137	138	139	140	141	142	143	144	145	146	147	148	149	150	151	152	153	154	155	156	157	158	159	160	161	162	163	164	165	166	167	168	169	170	171	172	173	174	175	176	177	178	179	180	181	182	183	184	185	186	187	188	189	190	191	192	193	194	195	196	197	198	199	200	201	202	203	204	205	206	207	208	209	210	211	212	213	214	215	216	217	218	219	220	221	222	223	224	225	226	227	228	229	230	231	232	233	234	235	236	237	238	239	240	241	242	243	244	245	246	247	248	249	250	251	252	253	254	255	256	257	258	259	260	261	262	263	264	265	266	267	268	269	270	271	272	273	274	275	276	277	278	279	280	281	282	283	284	285	286	287	288	289	290	291	292	293	294	295	296	297	298	299	300	301	302	303	304	305	306	307	308	309	310	311	312	313	314	315	316	317	318	319	320	321	322	323	324	325	326	327	328	329	330	331	332	333	334	335	336	337	338	339	340	341	342	343	344	345	346	347	348	349	350	351	352	353	354	355	356	357	358	359	360	361	362	363	364	365	366	367	368	369	370	371	372	373	374	375	376	377	378	379	380	381	382	383	384	385	386	387	388	389	390	391	392	393	394	395	396	397	398	399	400	401	402	403	404	405	406	407	408	409	410	411	412	413	414	415	416	417	418	419	420	421	422	423	424	425	426	427	428	429	430	431	432	433	434	435	436	437	438	439	440	441	442	443	444	445	446	447	448	449	450	451	452	453	454	455	456	457	458	459	460	461	462	463	464	465	466	467	468	469	470	471	472	473	474	475	476	477	478	479	480	481	482	483	484	485	486	487	488	489	490	491	492	493	494	495	496	497	498	499	500	501	502	503	504	505	506	507	508	509	510	511	512	513	514	515	516	517	518	519	520	521	522	523	524	525	526	527	528	529	530	531	532	533	534	535	536	537	538	539	540	541	542	543	544	545	546	547	548	549	550	551	552	553	554	555	556	557	558	559	560	561	562	563	564	565	566	567	568	569	570	571	572	573	574	575	576	577	578	579	580	581	582	583	584	585	586	587	588	589	590	591	592	593	594	595	596	597	598	599	600	601	602	603	604	605	606	607	608	609	610	611	612	613	614	615	616	617	618	619	620	621	622	623	624	625	626	627	628	629	630	631	632	633	634	635	636	637	638	639	640	641	642	643	644	645	646	647	648	649	650	651	652	653	654	655	656	657	658	659	660	661	662	663	664	665	666	667	668	669	670	671	672	673	674	675	676	677	678	679	680	681	682	683	684	685	686	687	688	689	690	691	692	693	694	695	696	697	698	699	700	701	702	703	704	705	706	707	708	709	710	711	712	713	714	715	716	717	718	719	720	721	722	723	724	725	726	727	728	729	730	731	732	733	734	735	736	737	738	739	740	741	742	743	744	745	746	747	748	749	750	751	752	753	754	755	756	757	758	759	760	761	762	763	764	765	766	767	768	769	770	771	772	773	774	775	776	777	778	779	770	771	772	773	774	775	776	777	778	779	780	781	782	783	784	785	786	787	788	789	790	791	792	793	794	795	796	797	798	799	800	801	802	803	804	805	806	807	808	809	8010	8011	8012	8013	8014	8015	8016	8017	8018	8019	8020	8021	8022	8023	8024	8025	8026	8027	8028	8029	8030	8031	8032	8033	8034	8035	8036	8037	8038	8039	8040	8041	8042	8043	8044	8045	8046	8047	8048	8049	8050	8051	8052	8053	8054	8055	8056	8057	8058	8059	8060	8061	8062	8063	8064	8065	8066	8067	8068	8069	8070	8071	8072	8073	8074	8075	8076	8077	8078	8079	8080	8081	8082	8083	8084	8085	8086	8087	8088	8089	8090	8091	8092	8093	8094	8095	8096	8097	8098	8099	80100	80101	80102	80103	80104	80105	80106	80107	80108	80109	80110	80111	80112	80113	80114	80115	80116	80117	80118	80119	80120	80121	80122	80123	80124	80125	80126	80127	80128	80129	80130	80131	80132	80133	80134	80135	80136	80137	80138	80139	80140	80141	80142	80143	80144	80145	80146	80147	80148	80149	80150	80151	80152	80153	80154	80155	80156	80157	80158	80159	80160	80161	80162	80163	80164	80165	80166	80167	80168	80169	80170	80171	80172	80173	80174	80175	80176	80177	80178	80179	80180	80181	80182	80183	80184	80185	80186	80187	80188	80189	80190	80191	80192	80193	80194	80195	80196	80197	80198	80199	80200	80201	80202	80203	80204	80205	80206	80207	80208	80209	80210	80211	80212	80213	80214	80215	80216	80217	80218	80219	80220	80221	80222	80223	80224	80225	80226	80227	80228	80229	80230	80231	80232	80233	80234	80235	80236	80237	80238	80239	80240	80241	80242	80243	80244	80245	80246	80247	80248	80249	80250	80251	80252	80253	80254	80255	80256	80257	80258	80259	80260	80261	80262	80263	80264	80265	80266	80267	80268	80269	80270	80271	80272	80273	80274	80275	80276	80277	80278	80279	80280	80281	80282	80283	80284	80285	80286	80287	80288	80289	80290	80291	80292	80293	80294	80295	80296	80297	80298	80299	80300	80301	80302	80303	80304	80305	80306	80307	80308	80309	80310	80311	80312	80313	80314	80315	80316	80317	80318	80319	80320	80321	80322	80323	80324	80325	80326	80327	80328	80329	80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9000

CERTIFICATE OF DEATH

08972

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md Wash., D.C.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Henryton 3 days		b. COUNTY Prince George	
c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 16X2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Henryton State Hospital		d. STREET ADDRESS 8720 Livingston Road	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print)	First Lucy	Middle Ford	Last Johnson	4. DATE OF DEATH August 24, 1960	Month Day Year
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5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 5-29-1888	9. AGE (In years last birthday) 72 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Brandywine, Maryland	12. CITIZEN OF WHAT COUNTRY? U. S. A.
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13. FATHER'S NAME Joseph Ford	14. MOTHER'S MAIDEN NAME Unknown
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. Unknown	17. INFORMANT Mamie Miller- 8720 Livingston Rd. Wash., D.C.	Address
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion	INTERVAL BETWEEN ONSET AND DEATH
002X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cardiovascular arteriosclerosis	
-046-10 (c) Moderately advanced pulmonary tuberculosis	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
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21. I certify that (I) (this hospital) attended the deceased from August 22, 1960, to August 24, 1960, that (I) (we) last saw the deceased alive on Aug. 24, 1960, and that death occurred at 6:35 p.m. from the causes and on the date stated above.

22a. SIGNATURE Dr. Edgars M. Maculans, Supt.	M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type) Edgars M. Maculans	22d. ADDRESS Henryton, Maryland	

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 8-28-60	23c. NAME OF CEMETERY OR CREMATORIUM Church	23d. LOCATION (City, town, or county) (State) Chapel Hill Maryland
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24. FUNERAL DIRECTOR'S SIGNATURE John T. Rhines Co.	ADDRESS 3015-12 th ST. N.E. D.C.	25a. REC'D BY REGISTRAR DATE AUG 30 '60	25b. REGISTRAR'S SIGNATURE Charles S. Kraus
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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial; cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 9001 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08973

Reg. Dist. No.

M

1. PLACE OF DEATH a. COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 25 yrs. 10 mos. 5 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
3. NAME OF DECEASED (Type or print) Charles		d. STREET ADDRESS 630 Cokesbury Ave.	
4. DATE OF DEATH August 9, 1960		5. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH July 9, 1899
9. AGE (In years last birthday) 61 yrs.	10. IF UNDER 1 YEAR Months 0 Days 0	11. IF UNDER 24 HRS. Hours 0 Mins. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY Noell	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles W. Killmon		14. MOTHER'S MAIDEN NAME Elizabeth A. White	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. - - -	
17. INFORMANT Springfield Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction INTERVAL BETWEEN ONSET AND DEATH minutes			
400-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Due to Coronary arteriosclerosis years			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Schizophrenic reaction, paranoid type. 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>James T. Marsh</i>		DATE SIGNED 8/10/60	
EXAMINER'S NAME (Type) James T. Marsh, M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Bury		22b. DATE THEREOF 8-18-60	22c. NAME OF CEMETERY OR CREMATORIUM Springfield Hospital
22d. LOCATION (City, town, or county) Oakhurst Crem. & Bur. Sykesville, Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur F. Haugst</i>		ADDRESS Sykesville, Md.	24a. REC'D BY REGISTRAR DATE AUG 23 '60
		24b. REGISTRAR'S SIGNATURE James S. Knapp	

EDUCATIONAL EXAMINER'S CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. **TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, it may be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

9002

CERTIFICATE OF DEATH

08974

1. PLACE OF DEATH a. COUNTY Carroll		Item 1 111m070 4560 et MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Baltimore City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 2 Mos. 16 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City, 30		d. STREET ADDRESS 3008 Woodring Ave.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First William	Middle Edward	Last Little	4. DATE OF DEATH 8	Month 8	Day 26	Year 1960
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/17/90		9. AGE (In years last birthday) 70 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Racetrack guard		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ?				14. MOTHER'S MAIDEN NAME Elizabeth O.		?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 218225872		17. INFORMANT Springfield State Hospital Record		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) Congestive Heart Failure							
INTERVAL BETWEEN ONSET AND DEATH Days							
Conditions, if any, which gave rise to immediate cause (o), stating the under- lying cause last. 454 (b) DUE TO Bilateral Pneumonia							
Days							
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) C.B.S. associated with Senile Brain Disease							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 6/ 10/ 1960 to 8/ 26/ 1960 , that (I) (we) last saw the deceased alive on 8/ 26/ 1960 , and that death occurred 5:45 p.m. M, from the causes and on the date stated above.							
22a. SIGNATURE Aguirre del Campo		M.D. <input type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 8/26/1960			
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 8-29-60		23c. NAME OF CEMETERY OR CREMATORIAL Baltimore National		23d. LOCATION (City, town, or county) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS Leonard J. Ruck 5305 Harford Rd.		25a. REC'D BY REGISTRAR DATE AUG 30 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Krause	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9003

CERTIFICATE OF DEATH

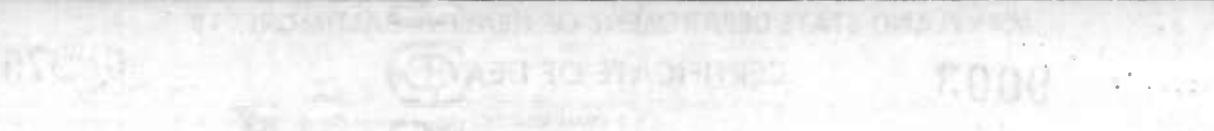
08975

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Darroll</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hampstead Road</i>		c. LENGTH OF STAY IN 1b <i>5 yrs</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>✓</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hampstead (Rural)</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <i>METTIE - J LUDWIG</i>		4. DATE OF DEATH Month Day Year <i>Aug 26 1960</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>June 30-1877</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>House</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>W.S.A.</i>	
13. FATHER'S NAME <i>Edmund Reed</i>		14. MOTHER'S MAIDEN NAME <i>Catherine Smith</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>210 210 210</i>	
17. INFORMANT <i>Betty Scoff. Hampstead Md</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerotic Heart Disease</i>		INTERVAL BETWEEN ONSET AND DEATH <i>5 yrs</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <i>420</i>			
(c) DUE TO <i>Arteriosclerosis Generalized</i>		5 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Name, form, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at <i>10p</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>W.H. Foard</i>		ADDRESS (Street, city or town, state) <i>Manchester, Md</i>	
PHYSICIAN'S NAME (Type) <i>W.H. Foard M.D.</i>		DATE SIGNED <i>8-29-60</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>8-31-60</i>	
22c. NAME OF CEMETERY OR CREMATORIUM <i>Manchester</i>		22d. LOCATION (City, town, or county) <i>Darroll Rd Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Edw Gipson - Hampstead Md</i>		24a. REC'D BY REGISTRAR DATE <i>SEP 1 '60</i>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

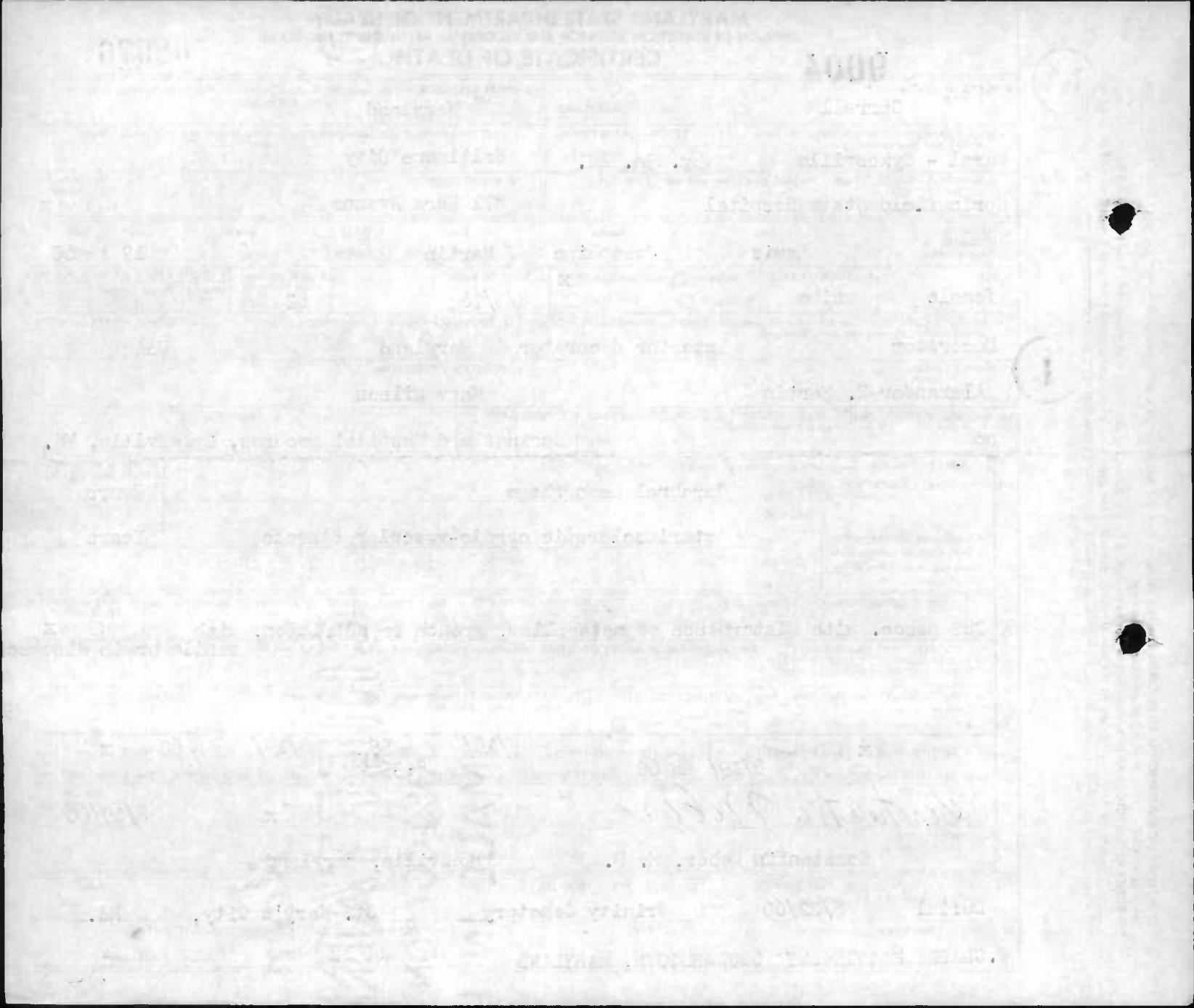
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

08976

M		9004		015		1		
1. PLACE OF DEATH a. COUNTY		Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		Maryland b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS		
Rural - Sykesville		5y. 3m. 1d.		Baltimore City		871 Park Avenue		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		Springfield State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First Mamie	Middle Josephine	Last Martin	4. DATE OF DEATH	Month 8	Day 19	Year 1960
5. SEX female		6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 8/3/78	9. AGE (In years last birthday) 82 yrs.	IF UNDER 1 YEAR Months 8	IF UNDER 24 HRS. Days 19	Hours 00
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
Decorator		Interior decorator		Maryland		USA		
13. FATHER'S NAME Alexander T. Martin		14. MOTHER'S MAIDEN NAME Mary Wilson						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT		Address		
				Springfield Hospital records, Sykesville, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]						INTERVAL BETWEEN ONSET AND DEATH Hours		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Cerebral hemorrhage						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO (b)		Arteriosclerotic cardio-vascular disease		Years		
		DUE TO (c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
CBS assoc. with disturbance of metabolism, growth or nutrition, with								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)				senile brain disease		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from _____ 5/18/1955 to 8/19/1960, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 8/19/1960, and that death occurred at 8:35 AM, from the causes and on the date stated above.								
22a. SIGNATURE Konstantin Weber		M.D.		ATTENDING PHYS. <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input checked="" type="checkbox"/>	22b. DATE SIGNED 8/19/60	
22c. PHYSICIAN'S NAME (Type) Konstantin Weber, M. D.		22d. ADDRESS		Sykesville, Maryland				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/22/60		23c. NAME OF CEMETERY OR CREMATORIUM Trinity Cemetery		23d. LOCATION (City, town, or county) St. Mary's City, Md. (State)		
24. FUNERAL DIRECTOR'S SIGNATURE W. CLARKE MATTINGLEY LEONARDTOWN, MARYLAND		ADDRESS		25a. REC'D BY REGISTRAR DATE AUG 23 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
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MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

9005

CERTIFICATE OF DEATH

08977

1. PLACE OF DEATH a. COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural--Eldersburg		c. LENGTH OF STAY IN lb 11 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Liberty Rd., P.O. Sykesville		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First ROBERT	Middle GEORGE	Last MILLER
4. DATE OF DEATH	Month August	Day 4,	Year 19 60
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 12, 1877
9. AGE (In years last birthday) 83 yrs.	10. IF UNDER 1 YEAR Months 54	11. IF UNDER 24 HRS. Days E. Patrick	12. CITIZEN OF WHAT COUNTRY? England
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman	10b. KIND OF INDUSTRY Visible Equipt.	11. BIRTHPLACE (State or foreign country) England	
13. FATHER'S NAME Harry Miller	14. MOTHER'S MAIDEN NAME Mary P. Harding		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) -----	16. SOCIAL SECURITY NO. 577-09-9519	17. INFORMANT Mr. Clarence C. Carty, Frederick, Md	Address 54 E. Patrick
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Arterosclerous generalized, cerebral DUE TO pneumonia, anemia - DUE TO	INTERVAL BETWEEN ONSET AND DEATH July 60 to 4 Aug 60		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 21 July 1960 to 4 Aug 1960 , that (I) (we) last saw the deceased alive on 4 Aug 1960 , and that death occurred at M. from the causes and on the date stated above.	22a. SIGNATURE Howard E. Hall		
22c. PHYSICIAN'S NAME (Type) Howard E. Hall M. D.	M.D. <input type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 4 Aug 60
23a. BURIAL, CREMATION (Specify) Burial	23b. DATE THEREOF Aug. 6, 1960	23c. NAME OF CEMETERY OR CREMATORIAL Mt. Olivet Cemetery	23d. LOCATION (City, town, or county) (State) Frederick, Maryland
24. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz, Winfield, Maryland	ADDRESS	25a. REC'D BY REGISTRAR DANIG 8 '60	25b. REGISTRAR'S SIGNATURE Charles S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

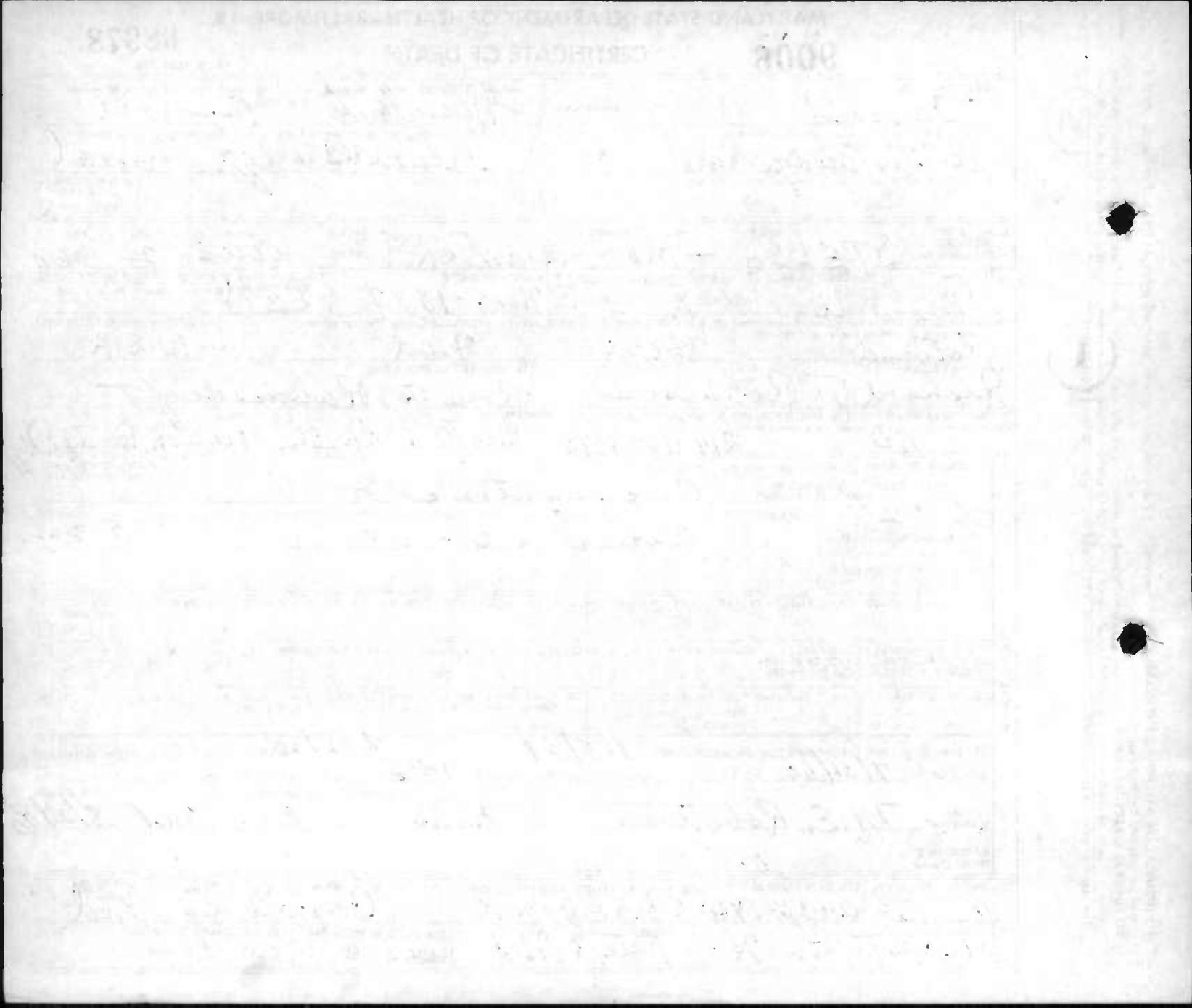
9006

CERTIFICATE OF DEATH

08978

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Carroll</i>	MARYLAND	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i>	b. COUNTY <i>Carroll</i>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Union Bridge Rural</i>	c. LENGTH OF STAY IN 1b <i>1 yr</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Union Bridge Rural</i>	d. STREET ADDRESS					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <i>STELLA - MAE MINNICK</i>	First	Middle	Last	4. DATE OF DEATH <i>Aug 2 1960</i>	Month	Day	Year	
S. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>Nov 8-1897</i>	9. AGE (In years last birthday) <i>62 yrs.</i>	IF UNDER 1 YEAR Months Days Hours Min.	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Neck</i>	11. BIRTHPLACE (State or foreign country) <i>Md</i>						
13. FATHER'S NAME <i>Richard F. Robinson</i>	14. MOTHER'S MAIDEN NAME <i>Rosa F. Ravenscroft</i>			Address <i>Mrs Fred Spalla Union Bridge Md</i>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>214-16-2398</i>	INFORMANT	INTERVAL BETWEEN ONSET AND DEATH					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>174X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							5 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>							20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>11/5/59</i> , 19, to <i>8/2/60</i> , 19, that I last saw the deceased alive on <i>7/31/60</i> , 19, and that death occurred at <i>1:40 AM</i> , from the causes and on the date stated above. ACTUAL SIGNATURE <i>M.E. Robertson</i> M.D. ADDRESS (Street, city or town, state) <i>New Windsor, Md</i> DATE SIGNED <i>8/2/60</i>							ADDRESS (Street, city or town, state) <i>New Windsor, Md</i> DATE SIGNED <i>8/2/60</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Aug 5-1960</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Pipe Creek</i>	22d. LOCATION (City, town, or county) <i>Carroll Co Md</i> (State)				
23. FUNERAL DIRECTOR'S SIGNATURE <i>Edw E. Tipton Hampstead Md</i>		ADDRESS <i>Edw E. Tipton Hampstead Md</i>	24a. REC'D BY REGISTRAR <i>Aug 4 '60</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Krause</i>				



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8983 CERTIFICATE OF DEATH

08979

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY CARROLL MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE MD b. COUNTY CARROLL		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WESTMINSTER		c. LENGTH OF STAY IN 1b 2 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WESTMINSTER	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 23 PARK AVE.			d. STREET ADDRESS 23 PARK AVE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print)	First MARY	Middle VIRGINIA	Last MOONEY	4. DATE OF DEATH Month Aug Day 6 Year 1960	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Oct. 3 1895	9. AGE (In years lost birthday) 64 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SCHOOL TEACHER.		10b. KIND OF BUSINESS OR INDUSTRY PUBLIC SCHOOL	11. BIRTHPLACE (State or foreign country) EASTON, PENNA.	12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME JOHN MOONEY			14. MOTHER'S MAIDEN NAME NORA AMBROSE		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service)			16. SOCIAL SECURITY NO. 208-26-875	17. INFORMANT MRS. EDWIN K. WADE, WESTMINSTER, MD.	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CA RECTUM - PERITONEAL METASTASIS			INTERVAL BETWEEN ONSET AND DEATH 1 yr -		
154X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour o. m. p. m.	Month, Day 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) M.D.	(County) (State)
21. I certify that I attended the deceased from 8-19, 1959, to 8-6, 1960, that I last saw the deceased alive on 8-6, 1960, and that death occurred at 10 A.M. from the causes and on the date stated above.					
ACTUAL SIGNATURE JAMES T. MARSH. ADDRESS (Street, city or town, state) PHYSICIAN'S NAME (Type) JAMES T. MARSH. 105 E MAIN ST WESTMINSTER MD					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF AUG. 10, '60		22c. NAME OF CEMETERY OR CREMATORIUM GETHSEMANE CEMETERY	
22d. LOCATION (City, town, or county) EPSTON, PENNA.		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE F. S. Myers Jr. Westminster, Md.			ADDRESS 24a. REC'D BY REGISTRAR DATE AUG 9 '60		
			24b. REGISTRAR'S SIGNATURE Arthur S. Kraus		

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.

04. ЗАЩИТА ОБРАЗОВАНИЯ И ПРОФЕССИЙ

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										Reg. Dist. No. ✓				
9007		Items 7 Film G271 9-14-60 et CERTIFICATE OF DEATH								118380				
1. PLACE OF DEATH a. COUNTY Carroll					b. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Sykesville					c. LENGTH OF STAY IN lb 7yr. 9mo. 07d.					b. COUNTY Washington				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown					d. STREET ADDRESS 954 LaVale St.				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
3. NAME OF DECEASED (Type or print)		First Earl	Middle Upton	Last Myers	4. DATE OF DEATH		Month 8	Day 28	Year 1960					
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH		9. AGE (In years last birthday) yrs. 58		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Railroader blacksmith railroad		11. BIRTHPLACE (State or foreign country) Maryland, Hagerstown		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown		16. SOCIAL SECURITY NO. 705-10-6598		17. INFORMANT		Address Records Springfield State Hospital				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]										INTERVAL BETWEEN ONSET AND DEATH years				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 3403 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO _____ (c) DUE TO _____										Meningoencephalitis				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic Brain Syndrome associated with central nervous system syphilis, meningo-encephalitis with psychotic reaction.										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ---												
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. --- 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ---		20f. (City or town) ---		(County) ---		(State) ---				
21. I certify that I attended the deceased from 7-1957 , 19, to Aug. 28 , 19, 60, that I last saw the deceased alive on Aug. 28 , 19, 60, and that death occurred at 8:25 P.M. , from the causes and on the date stated above.														
ADDRESS (Street, city or town, state) Springfield State Hospital														
DATE SIGNED 8-28-60														
ACTUAL SIGNATURE <i>Yasuo Takahashi</i>		PHYSICIAN'S NAME (Type) Yasuo Takahashi, M.D.		Sykesville, Maryland										
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-31-60		22c. NAME OF CEMETERY OR CREMATORIUM Rose Hill Cemetery				22d. LOCATION (City, town, or county) Hagerstown, Md.						
(State) ---														
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son, Hagerstown, Md.		ADDRESS		24a. REC'D BY REGISTRAR DATE AUG 31 '60		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Knapp</i>								

DEPARTMENT OF HEALTH - DIVISION OF
CERTIFICATE OF DEATH

At Merloas Station
Eric Resection

Age 58
P.B. 858

Sprinfield

Saksa

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with Page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

08981

9008

1. PLACE OF DEATH a. COUNTY Carroll		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Balto. County		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN lb 8 months 21 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		d. STREET ADDRESS 2914 North Wind Road		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First Charles	Middle Frederick	Last Neubert	4. DATE OF DEATH	Month 8	Day 27	Year 1960
5. SEX M		6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-7-1878		9. AGE (In years last birthday) 82 yrs.	10. IF UNDER 1 YEAR Months - Dots Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		10b. KIND OF BUSINESS OR INDUSTRY PAPER Box Co.		11. BIRTHPLACE (State or foreign country) Baltimore		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Ludwig NEULERT				14. MOTHER'S MAIDEN NAME CAROLINE MEINERT				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 212-10-3026		17. INFORMANT Springfield Hospital Records		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Suppurative bilateral Nephritis								
DUE TO 420.0								
Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Arteriosclerotic Heart Disease								
DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) CBS assoc. with cerebral arteriosclerosis, with psychotic reaction								
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								
MEDICAL CERTIFICATION								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Doy, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 11-6-59 to 8-27, 1960, that (I) (we) last saw the deceased alive on 8-27, 1960, and that death occurred at 2:45 PM, from the causes and on the date stated above.								
22a. SIGNATURE <i>Agustin del Campo</i>		M.D. ATTENDING PHYS. <input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input checked="" type="checkbox"/>		
22c. PHYSICIAN'S NAME (Type) Agustin Del Campo		22d. ADDRESS Springfield Hospital, Sykesville, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/31/60		23c. NAME OF CEMETERY OR CREMATORIAL Parkwood Crem		23d. LOCATION (City, town, or county) Balto Lo (Mu)		
24. FUNERAL DIRECTOR'S SIGNATURE <i>Chas F. Evans & Son</i>		ADDRESS 8802 Harbor Rd		25a. REC'D BY REGISTRAR DATE AUG 31 '60		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Krause</i>		

1299

1945-6-26

1000

1945-6-26

1945-6-26

1945-6-26

1945-6-26

1945-6-26

1945-6-26



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9009 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08982

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		CARROLL MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb 16 days		d. STATE Maryland b. COUNTY Frederick ✓	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
SPRINGFIELD STATE HOSPITAL		R.F.D.1 Knoxville 10 X-3			
3. NAME OF DECEASED (Type or print)		First CORINE	Middle SHANK	Last ORNDORFF	4. DATE OF DEATH Month 8 Day 20 Year 1960
5. SEX FEMALE		6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8-25-1902	9. AGE (In years last birthday) 57 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY HOME		11. BIRTHPLACE (State or foreign country) MARYLAND	
HOUSEWIFE				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CHARLES E. SHANK		14. MOTHER'S MAIDEN NAME CLARIA BELL MUMMER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Address HOSPITAL RECORDS	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RHEUMATIC OR MITRAL HEART DISEASE YEAR 410X DUE TO PULMONARY EDEMA HOUR Conditions, if any, which gave rise to immediate cause (b) (c) INSULIN SHOCK					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
DIABETES MELLITUS					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <i>James J. Moran</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 8/27/60	
EXAMINER'S NAME (Type)					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF 8-23-1960		22c. NAME OF CEMETERY OR CREMATORIAL <i>St. Paul Cemetery</i>	
22d. LOCATION (City, town, or county) <i>Baltimore Md</i>		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <i>D. Lee Testa</i>		ADDRESS <i>Baltimore Md</i>		24a. REC'D BY REGISTRAR AUG 21 1960	
				24b. REGISTRAR'S SIGNATURE <i>James L. Kline</i>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9010

CERTIFICATE OF DEATH

68983

Reg. Dist. No.

1. PLACE OF DEATH
o. COUNTY

Carroll Co

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Rural Westminster 56 yrs

c. LENGTH OF STAY IN 1b

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

Westminster Md. Rd #2

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)

o. STATE

Maryland

Carroll

b. COUNTY

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Rural Westminster, Md.

d. STREET ADDRESS

New London Road

e. IS RESIDENCE ON A FARM?

YES NO

3. NAME OF DECEASED (Type or print)

First

Middle

Last

4. DATE OF DEATH

Month

Day

Year

5. SEX

ALICE

ADELINE

PELTZ

AUGUST 28

1960

WHITE

WIDOWED

DIVORCED

B. DATE OF BIRTH

DEC. 27, 1903

9. AGE (In years lost birthday)

56

yrs.

10. IF UNDER 1 YEAR

Months

11. IF UNDER 24 HRS.

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, own if retired)

HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY

—

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

ELWOOD E. SNADER

14. MOTHER'S MAIDEN NAME

FLORENCE B. NUSBAUM

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)

NO

16. SOCIAL SECURITY NO.

212-24-540

17. INFORMANT

HUSBAND

Charles W. Petty, Sayre

Address

INTERVAL BETWEEN
ONSET AND DEATH
16 MOS

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

ADENOCARCINOMA OF THE OVARY

175.0 DUE TO

Conditions, if any, which
gave rise to immediate
cause (a), stating the under-
lying cause last.(b)
DUE TO
(c)

MEDICAL CERTIFICATION

Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED?
OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)YES NO 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

White

20c. TIME OF INJURY Month, Day, Year

Not white

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

at work

20f. (City or town)

(County)

(State)

Hour o. m.

19

p. m.

20d. INJURY OCCURRED

White

Not white

at work

at work

21. I certify that I attended the deceased from DEC. 14, 1959, to AUG. 28, 1960, that I last saw the deceased alive on AUG 28, 1960, and that death occurred at 120 PM, from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL
SIGNATURE

William Lewis Stewart, M.D.

19 RIDGE RD.

AUG. 28, 1960

PHYSICIAN'S
NAME (Type)

William Lewis STEWART

WESTMINSTER, MD.

22a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial Aug. 31, 1960, Westminster Cemetery, Rural New London, Md.

22b. DATE THEREOF

Aug. 31, 1960

22c. NAME OF CEMETERY OR CREMATORI

Westminster Cemetery

22d. LOCATION (City, town, or county)

Rural New London, Md.

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

J. E. Taylor, Jr., Westminster, Md.

ADDRESS

24a. REC'D BY REGISTRAR

Sep 1 '60

24b. REGISTRAR'S SIGNATURE

Arthur S. Trahan

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

9011

CERTIFICATE OF DEATH

08984

1. PLACE OF DEATH a. COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 5mos. 3days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) New Windsor	
3. NAME OF DECEASED (Type or print) Mary Virginia Hatfield		4. DATE OF DEATH August 21, 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 4, 1884
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY —	
10c. FATHER'S NAME Unknown		11. BIRTHPLACE (State or foreign country) Maryland	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
16. SOCIAL SECURITY NO. —		17. INFORMANT Amelia Porter	
		Address Springfield Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) C.B.S. assoc. with senile brain disease with psychotic reaction. 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from March 18, 1960 , to August 21, 1960 , that (I) (we) last saw the deceased alive on August 21, 1960 , and that death occurred at 6: P.M. from the causes and on the date stated above.			
22a. SIGNATURE <i>Agustin del Campo</i>		22b. DATE SIGNED 8/22/60	
22c. PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.		22d. ADDRESS Springfield Hospital, Sykesville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Aug. 24, 1960	
23c. NAME OF CEMETERY OR CREMATORIAL Taylorsville Cemetery		23d. LOCATION (City, town, or county) (State) Carroll Co., Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz, Winfield, Maryland		ADDRESS	
		25a. REC'D. BY REGISTRAR AUG 24 1960	
		25b. REGISTRAR'S SIGNATURE C. M. Waltz	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

08985

9012

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Carroll		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Carroll		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Middleburg		c. LENGTH OF STAY IN 1b 5 months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Taneytown		d. STREET ADDRESS 63 York Street		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Brookfield Manor Nursing Home						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Isaiah		First	Middle	Last	4. DATE OF DEATH August 13 1960	Month	Day	Year
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH March 3, 1872	9. AGE (In years last birthday) 88 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own Farm		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Isaiah William Reifsnider			14. MOTHER'S MAIDEN NAME Rebecca Lippy					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no			16. SOCIAL SECURITY NO. NONE		17. INFORMANT Mr. Raymond Reifsnider, Hanover, Pennsylvania		Address 323 East Hanover St., Hanover, Pennsylvania	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocarditis and Myocardial Degeneration 15 yrs. DUE TO (b) Coronary Arteriosclerosis 15 yrs. Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Deminalized Arteriosclerosis, Chronic Cystitis, Prostatitis								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 11/17/41 to 8/13/60 , that (I) (we) last saw the deceased alive on 8/13/60 , and that death occurred at A M, from the causes and on the date stated above.								
22a. SIGNATURE R. S. McVaugh		M.D.		ATTENDING MED. PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED AUG. 15, 1960	
22c. PHYSICIAN'S NAME (Type) R. S. McVaugh		22d. ADDRESS Taneytown, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Aug. 16, 1960		23c. NAME OF CEMETERY OR CREMATORIAL Reformed Cemetery		23d. LOCATION (City, town, or county) (State) Taneytown, Carroll, Maryland		
24. FUNERAL DIRECTOR'S SIGNATURE Arthur C. Fuss		ADDRESS Taneytown, Maryland		25a. REC'D BY REGISTRAR DATE AUG 17 '60		25b. REGISTRAR'S SIGNATURE Arthur C. Fuss		
C. S. Fuss & Son								

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9015 CERTIFICATE OF DEATH

18988

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Westminster, Md.		c. LENGTH OF STAY IN 1b 43 Yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION -----		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Westminster, Md.	
d. STREET ADDRESS R.D.#6 Westminster, Md.		e. IS RESIDENCE ON FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First William	Middle Edward	Last Sitterding
4. DATE OF DEATH			Month Aug. Day 13 Year 19 60
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/31/1883
9. AGE (In years lost birthday) 77 yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer	10b. KIND OF BUSINESS OR INDUSTRY poultry	11. BIRTHPLACE (State or foreign country) Balto. Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME John William Sitterding	14. MOTHER'S MAIDEN NAME Louise Besser		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. -----	INFORMANT son Mr. Edward G. Sitterding	Address R.D.#6 Westminster, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cerebral Hemorrhage			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Vascular disease			
DUE TO (c) sensilit			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) None			
INTERVAL BETWEEN ONSET AND DEATH 1 day			
5 years			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Aug. 15, 1960 to Aug. 13, 1960 that I last saw the deceased alive on Aug. 12, 1960 , and that death occurred at 6 A.M. from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) Dr. C. L. Billingslea M.D. Westminster, Md.			
DATE SIGNED 8-13-60			
MEDICAL CERTIFICATION			
ACTUAL SIGNATURE C. L. Billingslea			
PHYSICIAN'S NAME (Type) Dr. C. L. Billingslea			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial	22b. DATE THEREOF 8/16/60	22c. NAME OF CEMETERY OR CREMATORIUM Deer Park Cemetery	22d. LOCATION (City, town, or county) Smallwood (State) Md.
23. FUNERAL DIRECTOR'S SIGNATURE James J. Saffell Jr.	ADDRESS Westminster, Md.	24a. REC'D BY REGISTRAR DATE AUG 16 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Kline

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08986

1. PLACE OF DEATH a. COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Taneytown		c. LENGTH OF STAY IN 1b 60 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Taneytown	
		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First Samuel	Middle David
Last Snider		4. DATE OF DEATH Month August	
Day 21		Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH January 4, 1874
		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. AGE (In years last birthday) 86 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Day Labor	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William A. Snider		14. MOTHER'S MAIDEN NAME Alice Bower	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Mrs. Carl Baumgardner, Littlestown, Penna.	
17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) 420.1		INTERVAL BETWEEN ONSET AND DEATH 5 min.	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Arteriovenous Thrombosis		(c) DUE TO Arteriosclerotic Cardio-Vascular Disease	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 8/24/59 to 8/21/60 , that (I) (we) last saw the deceased alive on 8/15/60 and that death occurred at home , from the causes and on the date stated above.		22b. DATE SIGNED 8/22/60	
22a. SIGNATURE R. L. Potter		M.D. <input checked="" type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22d. ADDRESS LITTLESTOWN, PA.
22c. PHYSICIAN'S NAME (Type) L. L. POTTER M.D.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Aug. 24, 1960	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Harney Lutheran Cemetery		23d. LOCATION (City, town, or county) (State) Harney, Carroll, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Merle G. Fuss		25a. REC'D BY REGISTRAR DATE AUG 25 '60	
C.O. Fuss & Son, Taneytown, Md.		25b. REGISTRAR'S SIGNATURE John S. Kline	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9014 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 9 FilmG269 8-17-60 et

118987

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "postponed" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your information.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Balt. City ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 1 mo. 12 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 14 3V01-4	
3. NAME OF DECEASED (Type or print) Estelle Mae Hopkins		First Spicer	Middle Last 4. DATE OF DEATH August 12, 1960
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 1884 January 15, 1884 76 7/4 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Hopkins		14. MOTHER'S MAIDEN NAME Mary -	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. - 17. INFORMANT Springfield Hospital Records	
Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)			
DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH Years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) C.B.S. assoc. with senile brain disease with psychotic reaction.			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>James T. Marsh</i>		DATE SIGNED 8/12/60	
EXAMINER'S NAME (Type) James T. Marsh, M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial	22b. DATE THEREOF 8-15-60	22c. NAME OF CEMETERY OR CREMATORIUM Woodlawn Cemetery	22d. LOCATION (City, town, or county), (State) Baltimore, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck 5305 Harford Rd		24a. REC'D BY REGISTRAR DATE AUG 15 '60	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Thrasher</i>

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9016 CERTIFICATE OF DEATH

118989

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Carroll</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural Westminster Rd #17591</i>		c. LENGTH OF STAY IN 1b <i>1 year</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Western Chapel Road</i>		e. STREET ADDRESS <i>Western Chapel Road</i>	
3. NAME OF DECEASED (Type or print)	First <i>MARY</i>	Middle <i>ELIZABETH</i>	Last <i>THOMAS</i>
4. DATE OF DEATH	Month <i>AUGUST</i>	Day <i>30</i>	Year <i>1960</i>
5. SEX <i>FEMALE</i>	6. COLOR OR RACE <i>NEGRO</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>JUNE 1, 1877</i>
9. AGE (In years lost birthday) <i>83</i>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Annister</i>	11. KIND OF BUSINESS OR INDUSTRY <i></i>	12. BIRTHPLACE (State or foreign country) <i>Carroll Co. Md</i>
13. FATHER'S NAME <i>Israel Adams</i>	14. MOTHER'S MAIDEN NAME <i>Rebecca ?</i>	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>—</i>	
16. SOCIAL SECURITY NO. <i>216-32-6935</i>		17. INFORMANT <i>Mrs. Ruth M. Fletcher Same address</i>	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CONGESTIVE HEART FAILURE</i> DUE TO Conditions, if any, which gave rise to immediate cause, stating the under- lying cause last. <i>443X</i> (b) <i>HYPERTENSIVE ARTERIOSCLEROTIC</i> DUE TO (c) <i>CARIOVASCULAR DISEASE</i> INTERVAL BETWEEN ONSET AND DEATH <i>1 DAY</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i></i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) <i>Westminster</i> (State) <i>Md.</i>
21. I certify that I attended the deceased from <i>JUL 4, 1959</i> to <i>AUG. 30, 1960</i> , that I last saw the deceased alive on <i>AUG 30, 1960</i> , and that death occurred at <i>11:55 AM</i> , from the causes and on the date stated above. ACTUAL SIGNATURE <i>William J. Stewart, M.D.</i> ADDRESS (Street, city or town, state) <i>19 RIDGE RD WESTMINSTER, MD</i> DATE SIGNED <i>AUG. 30, 1960</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial Sept. 3, 60</i>		22b. DATE THEREOF <i>Sept. 3, 60</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Western Cemetery New London Rd #1</i>
22d. LOCATION (City, town, or county) <i>New London</i>		(State) <i>Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. E. Myers Jr. Westminster, Md.</i>		ADDRESS <i>105 Westminster, Md.</i>	24a. REC'D BY REGISTRAR <i>DATEP 1 '60</i>
			24b. REGISTRAR'S SIGNATURE <i>John E. Myers Jr.</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with
 page 3 should be detached for use as the burial-trust permit. Then please remove carbon paper. Page 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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FOR STATE
HEALTH DEPT.



TO DEPUTY MEDICAL EXAMINER: A certificate should be executed within 24 hours after death. If "pending" in pencil in Item 18, Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 18 Film 275 11-23-60

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8984 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

118990

1. PLACE OF DEATH

a. COUNTY

Carroll

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Westminster

c. LENGTH OF STAY IN lb

1 yr. 1 day.

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

19 Ridge Road

First

Middle

Last

3. NAME OF
DECEASED
(Type or print)

WILLIAM

R.

VEIGA

4. SEX

Male

6. COLOR OR RACE

White

7. MARRIED NEVER MARRIED

WIDOWED

DIVORCED

8. DATE
OF
DEATH

Dec 3, 1957

Month

August

Day

15

Year

1960

9. AGE (In years
last birthday)

2 yrs.

IF UNDER 1 YEAR

Months

Days

IF UNDER 24 HRS.

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

I Joseph V. Vega Jr.

15. WAS DECEASED EVER IN U.S. ARMED FORCES
(Yes, no, or unknown) (If yes, give rank or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

14. MOTHER'S MAIDEN NAME

Jane Gillespie Address 54 Chase St.
Mr. Jos. V. Vega, Jr., Postmaster, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE: Acute, interstitial pneumonitis, bilateral

INTERVAL BETWEEN
ONSET AND DEATH

492 X

DUE TO

(b)

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?

YES NO

20a. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING
CAUSE OF DEATH.

2db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m.
p.m.

20d. INJURY OCCURRED
While at work Not While at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion
death resulted from: Natural causes Accident Suicide Homicide Undetermined manner

ACTUAL
SIGNATURE

Russell S Fisher

CHIEF MEDICAL EXAMINER

EXAMINER'S
NAME (Type)

Russell S. Fisher, M.D.

ASSISTANT MEDICAL EXAMINER

DATE SIGNED

8/15/60

DEPUTY MEDICAL EXAMINER

Address (Street, city, town, or county)

22a. BURIAL, CREMATION,
REMOVAL (Specify)

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORIUM

22d. LOCATION (City, town, or country)

(State)

23. FUNERAL DIRECTOR

ADDRESS

REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

REMOVAL 8/16, 1960 Calvary Cemetery
J. E. Myers Jr., Westminster, Md.

Chicopee, Mass.

DATE AUG 18 '60

Clifford S. Kraus

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

08991

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. City		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville	c. LENGTH OF STAY IN 1b 4 yrs. 3 mos. 22 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 24		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital			d. STREET ADDRESS 505 S. East Ave. 3V61-4		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED First June Esther Middle Wisniewski Wallace		Lost		4. DATE OF DEATH	Month Day Year
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH June 25, 1899		9. AGE (In years lost birthday) 61 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None House wife		10b. KIND OF BUSINESS OR INDUSTRY 217-20-2346		11. BIRTHPLACE (State or foreign country) Michigan	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Albert Wisniewski			14. MOTHER'S MAIDEN NAME Ida - Staniewski		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. -		
17. INFORMANT Mr. R. Wallace 1923 Address Quentine Rd 2			Springfield Hospital Records		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) Arteriosclerotic cardiovascular disease INTERVAL BETWEEN ONSET AND DEATH Years					
422 DUE TO Pyelonephritis Weeks					
Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause lost. (b) DUE TO Bronchopneumonia Days					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Schizophrenic reaction, paranoid type. 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year	Hour o.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)
21. I certify that (I) (this hospital) attended the deceased from May 31, 1955, to August 23, 1960, that (I) (we) last saw the deceased alive on August 23, 1960, and that death occurred at 8:10 PM from the causes and on the date stated above.					
22a. SIGNATURE Agustin del Campo			22b. DATE SIGNED 8/24/60		
22c. PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.			22d. ADDRESS Springfield Hospital, Sykesville, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/27/60		23c. NAME OF CEMETERY OR CREMATORIAL St. Stanislaus	
23d. LOCATION (City, town, or county) Balto. City		(State) Md.			
24. FUNERAL DIRECTOR'S SIGNATURE Wm. S. Fialkowski 2007 Eastern Ave.			25a. REC'D BY REGISTRAR DATE AUG 25 1960		25b. REGISTRAR'S SIGNATURE

Memorandum



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

9018

CERTIFICATE OF DEATH

118992

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 28 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		d. STREET ADDRESS 806 Mulberry Ave.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First Rudolph	Middle Max	Last Weiss	4. DATE OF DEATH August	Month 25,	Year 1960
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 10, 1883		9. AGE (In years last birthday) 76 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Silk mill employee		10b. KIND OF BUSINESS OR INDUSTRY WEAVER		11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? U.S.A., Unknown	
13. FATHER'S NAME Unknown ADOLPH WEISS				14. MOTHER'S MAIDEN NAME Agnes Elsberg			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. No - 151-05-099		17. INFORMANT Springfield Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) C.B.S. associated with senile brain disease.							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m.	20d. Month 19	20e. Day Nat while at work <input type="checkbox"/> at work <input type="checkbox"/>	20f. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that (I) (this hospital) attended the deceased from July 27, 1960, to August 25, 1960, that (I) (we) last saw the deceased alive on August 25, 1960, and that death occurred at 10:15 AM from the causes and on the date stated above.							
22a. SIGNATURE Agustin del Campo, M.D.				22b. DATE SIGNED 8/25/60			
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS Springfield Hospital, Sykesville, Md.					
23a. BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF 8/27/60		23c. NAME OF CEMETERY OR CREMATORIUM Cedar Haven Cem.		23d. LOCATION (City, town, county) Hagerstown, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE W.J. Normant, Hagerstown, Md.				ADDRESS		25a. REC'D BY REGISTRAR DATE AUG 29 1960	25b. REGISTRAR'S SIGNATURE Arthur S. Turner

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been filled in by the funeral director,

page 3 should be detached for use as the burial permit by the State Board of Health prior to burial.

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

9019

CERTIFICATE OF DEATH

08993

1. PLACE OF DEATH a. COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Henryton		b. COUNTY St. Mary's	
c. LENGTH OF STAY IN 1b 180 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Colton's Point	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Henryton State Hospital		d. STREET ADDRESS 18 X-2	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Alias Walter Jefferson Middle Walter Thomas Young		4. DATE OF DEATH August 20, 1960	Month Day Year
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-1-1874
9. AGE (In years lost birthday) 86 yrs.		10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Oyster Shucker		10b. KIND OF BUSINESS OR INDUSTRY St. Mary's Co., Md.	
11. BIRTHPLACE (State or foreign country) St. Mary's Co., Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Thomas Young		14. MOTHER'S MAIDEN NAME Henrietta Young	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 17. INFORMANT Walter Thomas Young - Patient	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) 002 X		Cardiovascular insufficiency	
DUE TO Part II Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Arteriosclerotic heart disease			
DUE TO Moderately advanced pulmonary Tbc.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Doy. Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Feb. 22, 1960 to Aug. 20, 1960 , that (I) (we) last saw the deceased alive on Aug. 20, 1960 , and that death occurred at 310 W , from the causes and on the date stated above.		22b. DATE SIGNED	
22o. SIGNATURE Edgars M. Maculans		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) Dr. Edgars M. Maculans, Supt.		22d. ADDRESS Henryton State Hospital, Henryton, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/23/60	23c. NAME OF CEMETERY OR CREMATORIAL All Saints
24. FUNERAL DIRECTOR'S SIGNATURE W. CLARKE MATTINGLEY		ADDRESS LEONARDTOWN, MARYLAND	25a. REC'D BY REGISTRAR DATE AUG 23 '60
			25b. REGISTRAR'S SIGNATURE Arthur S. Knapp

9100

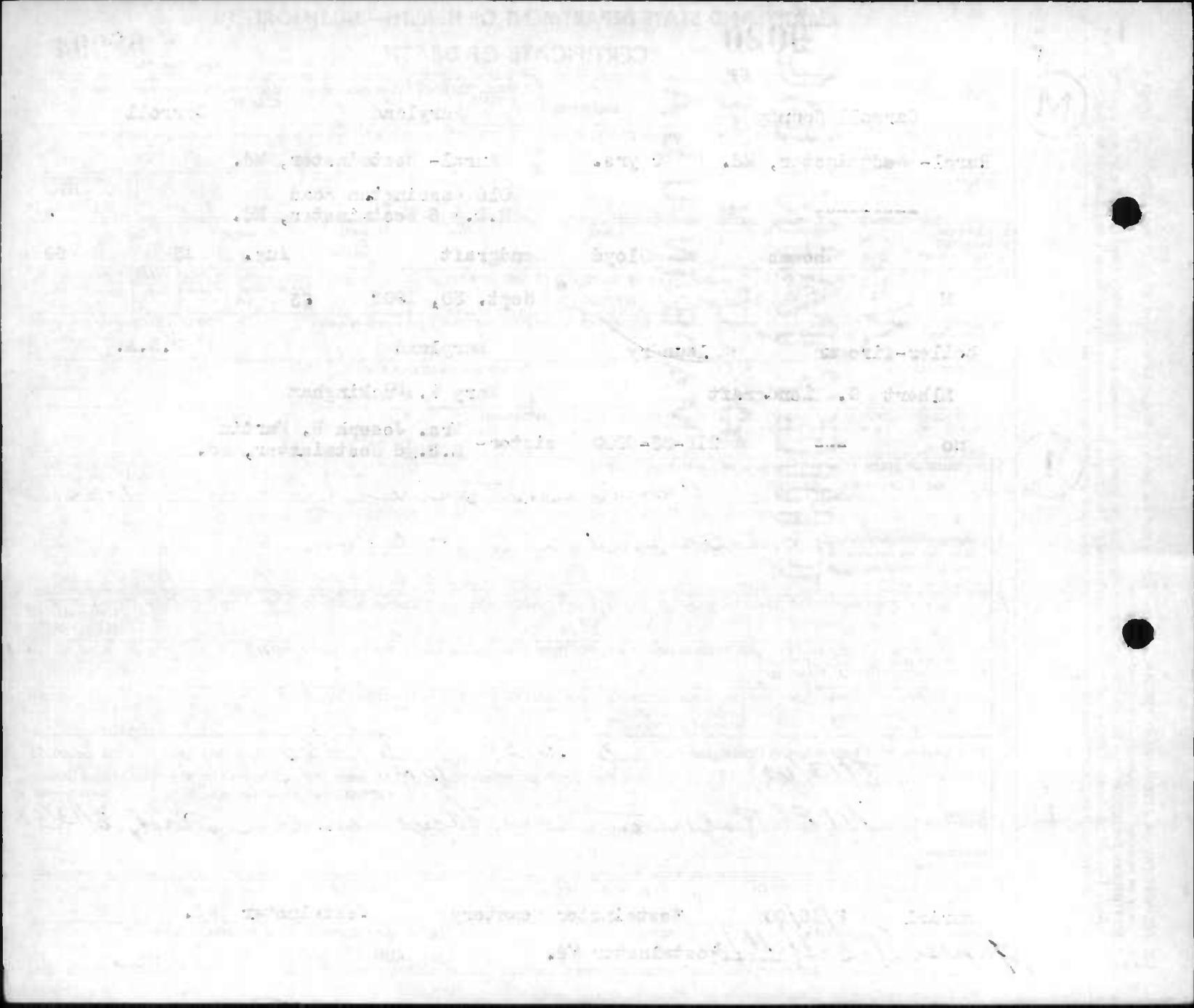
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9020 CERTIFICATE OF DEATH

118394

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Carroll County		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural- Westminster, Md.		c. LENGTH OF STAY IN lb 5 yrs.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION -----		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural- Westminster, Md.		
3. NAME OF DECEASED (Type or print) Thomas		First Gloyd	Middle Zendraft	
4. DATE OF DEATH Aug. 13 1960	Last	Month	Day Year	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 30, 1906	
9. AGE (In years last birthday) 53 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) boiler-firemen	11. KIND OF BUSINESS OR INDUSTRY laundry	12. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Albert G. Zendraft	14. MOTHER'S MAIDEN NAME Mary E. Buckingham			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. 218-03-6900	INFORMANT Mrs. Joseph H. Martin sister - R.D.#6 Westminster, Md.	Address 12. CITIZEN OF WHAT COUNTRY? U.S.A.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] Carcinomatosis 153.8 PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)				
INTERVAL BETWEEN ONSET AND DEATH 1 yr.				
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8/30/58 , to 8/13/60 , 19, that I last saw the deceased alive on 8/13/60 , 19, and that death occurred at 10 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) New Windsor, Md. DATE SIGNED ACTUAL SIGNATURE M.E. Robertson M.D. 8/13/60				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/16/60	22c. NAME OF CEMETERY OR CREMATORIUM Westminster Cemetery	22d. LOCATION (City, town, or county) Westminster Md. (State)
23. FUNERAL DIRECTOR'S SIGNATURE JAMES G. Saffell Jr.		ADDRESS Westminster Md.	24a. REC'D BY REGISTRAR Cynthia S. Thomas	24b. REGISTRAR'S SIGNATURE Cynthia S. Thomas



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9021 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

118995

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Baltimore City		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 20 yrs. 4 mos. 14 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		d. STREET ADDRESS 3111-4 1212 W. Pratt St.		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First Pearl	Middle	Last Ziegler	4. DATE OF DEATH August 4, 1960	Month	Day	Year	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH July 23, 1899	9. AGE (In years from birthday) 61 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerical work		10b. KIND OF BUSINESS OR INDUSTRY Yank		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Andrew Ziegler		14. MOTHER'S MAIDEN NAME Margaret Yakel						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. - - -		17. INFORMANT Springfield Hospital Records.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 420-1 (b) A.S.C.V. disease DUE TO (c)								
INTERVAL BETWEEN ONSET AND DEATH Days years								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Schizophrenic reaction, paranoid type. Free at hip								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Patient fell to the floor on the ward.						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year 7:00 PM 7/17/1960		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hospital		20f. (City or town) Sykesville	(County) Carroll	(State) Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE <i>James T. Marsh</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>						DATE SIGNED 8/4/60	
EXAMINER'S NAME (Type) James T. Marsh, M.D.								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8-8-60	22c. NAME OF CEMETERY OR CREMATORIUM New Cathedral		22d. LOCATION (City, town, or county) Baltimore Md.		(State)		
23. FUNERAL DIRECTOR'S SIGNATURE <i>John J. Flaherty</i>	ADDRESS Sykesville, Md.			24a. REC'D BY REGISTRAR AUG 10 '60	24b. REGISTRAR'S SIGNATURE Cynthia S. Traud			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "per" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

